

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **NISHITH S. SHAH, M.D.**

4 Holder of License No. 31035
5 For the Practice of Allopathic Medicine
6 In the State of Arizona.

Case No. MD-15-0144A

**FINDINGS OF FACT, CONCLUSIONS
OF LAW AND ORDER FOR LETTER
OF REPRIMAND AND PROBATION**

7 The Arizona Medical Board ("Board") considered this matter at its public meeting on
8 August 3, 2016. Nishith S. Shah, M.D. ("Respondent"), appeared with legal counsel
9 Christopher Smith, Esq., before the Board for a Formal Interview pursuant to the authority
10 vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact,
11 Conclusions of Law and Order after due consideration of the facts and law applicable to
12 this matter.

13 **FINDINGS OF FACT**

14 1. The Board is the duly constituted authority for the regulation and control of
15 the practice of allopathic medicine in the State of Arizona.

16 2. Respondent is the holder of license number 31035 for the practice of
17 allopathic medicine in the State of Arizona.

18 3. The Board initiated case number MD-15-0144A after receiving a self-report
19 from Respondent on his renewal application stating that his care and treatment of a patient
20 was under investigation by the Arizona Dental Board ("Dental Board") as a result of an
21 adverse occurrence after anesthesia administration.

22 4. On November 17, 2010, Respondent performed oral surgery on 68 year-old
23 male patient CN. Respondent administered Droperidol, Propofol, Ketamine, and
24 Midazolam via IV for sedation. While CN was under IV sedation, his blood oxygen
25 saturation level dropped by 50% after Respondent administered Labetolol and the patient

1 became asystolic. Respondent and his surgical team initiated resuscitative efforts
2 including compressions and administration of Naloxone and Flumazenil, but CN did not
3 recover and was pronounced dead at the hospital.

4 5. On July 15, 2011, the Dental Board issued a disciplinary order requiring
5 Respondent to complete 16 hours of continuing medical education ("CME") ("Dental Board
6 Order"). Respondent subsequently appealed the Dental Board Order; however, the
7 Arizona Court of Appeals ultimately upheld the Dental Board's decision. As of March 16,
8 2015, Respondent completed the CME required by the Dental Board Order.

9 6. A Medical Consultant ("MC") reviewed the case and identified deviations
10 from the standard of care with regard to Respondent's care and treatment of CN.

11 7. The standard of care requires a physician to obtain pre-operative clearance
12 by a primary care physician, including a 12 lead EKG. Respondent deviated from the
13 standard of care by failing to obtain pre-operative clearance from CN's primary care
14 physician.

15 8. The standard of care requires a physician to have continuous EKG and
16 ETCO2 monitoring. Respondent deviated from the standard of care by failing to have
17 continuous EKG and ETCO2 monitoring.

18 9. The standard of care requires a physician and at least one member of his
19 operative room staff to be Advanced Cardiac Life Support ("ACLS") certified and follow
20 American Heart Association ("AHA") ACLS protocol. Respondent deviated from the
21 standard of care by failing to designate an ACLS certified provider to monitor and
22 administer medication.

23 10. The standard of care requires a physician to document the indication for use
24 of medications used both during the procedure and code. Respondent deviated from the
25

1 standard of care by failing to document the indication for use of Droperidol, Flumazenil,
2 and Naloxone.

3 11. The standard of care requires a physician to provide intensive and
4 continuous monitoring of Propofol and Labetolol. Respondent deviated from the standard
5 of care by failing to provide continuous monitoring while using Propofol and Labetolol.

6 12. Patient CN suffered cardiac arrest and expired.

7 13. During a Formal Interview on this matter, Respondent testified that he
8 completed six months of residency training in anesthesia during his oral/maxillofacial
9 surgical residency, which is standard. Respondent testified that his goal with Patient CN
10 was deep to moderate sedation, with administration of propofol and airway management.
11 Respondent stated that while he was ACLS certified, his two assistants were not.

12 14. During that same Formal Interview, Board members expressed concern with
13 regard to the Respondent's level of understanding about different types of anesthesia as
14 well as the manner in which the anesthesia was administered to patient CN. One Board
15 member, who is an anesthesiologist, stated that further review by an oral surgeon was
16 unnecessary, as the Respondent appeared to lack understanding about basic
17 anesthesiology concepts.

18 CONCLUSIONS OF LAW

19 1. The Board possesses jurisdiction over the subject matter hereof and over
20 Respondent.

21 2. The conduct and circumstances described above constitute unprofessional
22 conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate
23 records on a patient.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

2. Respondent is placed on Probation for a period of 6 months with the following terms and conditions:

3. Continuing Medical Education

Respondent shall within 6 months of the effective date of this Order obtain no less than 15 hours of Board staff pre-approved Category I Continuing Medical Education ("CME") in an intensive, in-person course regarding sedation and general anesthesia. Respondent shall within **thirty days** of the effective date of this Order submit his request for CME to the Board for pre-approval. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure. The Probation shall terminate upon Respondent's proof of successful completion of the CME.

4. The Board retains jurisdiction and may initiate new action based upon any violation of this Order.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a

1 rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after
2 date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed,
3 the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

4 Respondent is further notified that the filing of a motion for rehearing or review is
5 required to preserve any rights of appeal to the Superior Court.

6 DATED AND EFFECTIVE this 5th day of October, 2016.

7
8 ARIZONA MEDICAL BOARD

9 By Patricia E. McSorley
10 Patricia E. McSorley
11 Executive Director

12 EXECUTED COPY of the foregoing mailed
13 this 5th day of October, 2016 to:

14 Christopher Smith, Esq.
15 Smith Law Group
16 Davis House
17 262 N Main Ave
Tucson, AZ 85701-8220
Attorney for Respondent

18 ORIGINAL of the foregoing filed
19 this 5th day of October, 2016 with:

20 Arizona Medical Board
21 9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

22 Mary Pooley
Board staff